COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS

REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 3 - THORACIC OUTLET SYNDROME VASCULAR ORIGIN - VENOUS

I. Narrative Description:

A. Thoracic Outlet Release - Venous

II. History/Symptoms:

A. Must meet three of the following present in the affected upper extremity
1. Pain; **or**
2. Swelling or heaviness; **or**
3. Decreased temperature or change in color; **or**
4. Paresthesis in the ulnar nerve distribution

AND

III. Physical Findings:

A. Must meet one of the following:
1. Swelling or venous engorgement; **or**
2. Cyanosis; **or**
3. Dilation of veins

AND

IV. Diagnostic Testing:

A. Must meet one of the following:
1. Abnormal venogram; **or**
2. Abnormal plethysmography

V. Special Instructions:

A. *None*

VI. Level of Care Required:

A. *Inpatient*

COMMONWEALTH OF MASSACHUSETTS
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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 4 - THORACIC OUTLET SYNDROME VASCULAR ORIGIN - ARTERIAL

I. Narrative Description:

A. Thoracic Outlet Release - Arterial

II. History/Symptoms:

A. Must meet three of the following present in the affected upper extremity
- **1.** Pain; **or**
- **2.** Swelling or heaviness; **or**
- **3.** Decreased temperature or change in color; **or**
- **4.** Paresthesis in the ulnar nerve distribution

AND

III. Physical Findings:

A. Must meet one of the following:
- **1.** Pallor or coolness; **or**
- **2.** Gangrene of the digits in advanced cases

AND

IV. Diagnostic Testing:

A. Must meet one of the following:
- **1.** Abnormal arteriogram; **or**
- **2.** Abnormal doppler ultrasonography

V. Special Instructions:

A. *None*

VI. Level of Care Required:

A. *Inpatient*

COMMONWEALTH OF MASSACHUSETTS
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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 5 - THORACIC OUTLET SYNDROME NEUROGENIC ORIGIN

I. Narrative Description:

A. Thoracic Outlet Release - Neurogenic

II. History/Symptoms:

A. Must meet the following in the affected upper extremities
- **1.** Pain; **and**
- **2.** Paresthesis (numbness, prickling, in the ulnar nerve distribution - side of forearm opposite thumb

AND

III. Physical Findings:

A. Must meet two of the following test that exactly reproduce symptoms of pain with or without pulse obliteration in the affected upper extremity:
- **1.** Roos maneuver; **or**
- **2.** Adson's maneuver; **or**
- **3.** Costoclavicular maneuver; **or**
- **4.** Hyperabduction maneuver

AND

IV. Diagnostic Testing:

A. Positive test findings on one of the following the affected upper extremity:
- **1.** Positive doppler ultrasonography; **or**
- **2.** Positive nerve conduction studies; **or**
- **3.** EMG; **or**
- **4.** Somatosensory evoked potential studies; **or**
- **5.** X-ray studies that confirm the presence of cervical ribs, elongated C-7 process, hypoplastic first rib, or fractured clavicle.

AND

B. Failure to improve after three months of conservative treatment; and

C. A second surgical opinion is obtained from a non-surgical specialist (e.g., neurologist, physiatrist, or rheumatologist).

V. Special Instructions:

A. *A psychiatrist or psychological evaluation may be required on a case-specific basis.*

VI. Level of Care Required:

A. *Inpatient*

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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 6 - ROTATOR CUFF REPAIR SHOULDER

I. Narrative Description:

A. Rotator Cuff Repair

II. History/Symptoms:

A. Must meet the following:
- **1.** Severe shoulder pain; **and**
- **2.** Inability to raise shoulder

AND

III. Physical Findings:

A. Must meet **A** and **B** or **C**
- **1.** Weak or absent abduction; **and**
- **2.** Tenderness over rotator cuff; **or**
- **3.** Pain relief with an injection of anesthetic for a diagnostic/therapeutic trial

AND

IV. Diagnostic Testing:

A. Must meet one of the following:
- **1.** Positive MRI; **or**
- **2.** Positive ultrasound; **or**
- **3.** Positive findings on arthrogram; **or**
- **4.** Positive findings on previous arthroscopy

AND

V. Failure to improve with outpatient therapy and conservative treatment for:

A. Acute cases - one to three weeks; **or**

B. Erosive cases
- **1.** Three months if treatment is continuous; **and**
- **2.** Six months if treatment is intermittent

VI. Special Instructions:

A. *Cervical pathology and frozen shoulder syndrome should be ruled out prior to an operative procedure.*

VII. Level of Care Required:

A. *Inpatient*

COMMONWEALTH OF MASSACHUSETTS
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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 7 - ANTERIOR ACROMIONECTOMY FOR ACROMIAL IMPINGEMENT SYNDROME SHOULDER

I. Narrative Description:

A. Anterior Acromionectomy

II. History/Symptoms:

A. Must meet the following:
- **1.** Failure to improve with four to six months of conservative treatment; **and**
- **2.** Pain with active arc motion 90-130 degrees; **and**
- **3.** Pain at night

AND

III. Physical Findings:

A. Positive impingement test and relief of pain with anesthetic injection

AND

IV. Radiologic Findings:

A. Coraco-acromial x-ray to document status of bony arch.

V. Special Instructions:

A. *None*

VI. Level of Care Required:

A. *Inpatient - But arthroscopic repair may not require an inpatient stay.*

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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 8 - REPAIR OF AC OR CC LIGAMENTS
ACROMIO-CLAVICULAR SEPARATION
SHOULDER

I. Narrative Description:

A. Repair of AC or CC Ligaments

II. History/Symptoms:

A. Must meet the following:
1. Localized pain at AC joint

AND

III. Physical Findings:

A. Prominent distal clavicle

AND

IV. Diagnostic Testing:

A. Radiographic findings of separation of AC joint with weight bearing films

AND

V. Failure of Bracing Treatment:

A. Those separations that can not be reduced and held in a brace; **or**

B. Those separations that do not improve after a one week trial period in a support brace

VI. Special Instructions:

A. *None*

VII. Level of Care Required:

A. *Outpatient or Inpatient depending on patient*

COMMONWEALTH OF MASSACHUSETTS
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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 9 - MUMFORD PROCEDURE
ACROMIO-CLAVICULAR SEPARATION
SHOULDER

I. Narrative Description:

A. Excision of distal clavicle

II. History/Symptoms:

A. Must meet the following:
- **1.** Failure to improve with 30-60 days of conservative treatment; **and**
- **2.** Pain at AC joint:
- **3.** Aggravation of pain with motion; **or**
- **4.** Aggravation of pain with weight carrying

AND

III. Physical Findings:

A. Must meet **1** and one from **2** or **3**
- **1.** Confirmation that separation of AC joint is unresolved; **and**
- **2.** Prominent distal clavicle; **or**
- **3.** Pain relief obtained with an injection of an anesthetic for diagnostic/therapeutic trial

AND

IV. Diagnostic Testing:

A. Must meet one of the following:
- **1.** Separation of AC joint with weight bearing films; **or**
- **2.** Severe DJD at AC joint noted on x-ray

V. Special Instructions:

A. *None*

VI. Level of Care Required:

A. *Outpatient or Inpatient depending on patient*

COMMONWEALTH OF MASSACHUSETTS
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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 10 - OPEN BANKART OR BRISTOW FOR RECURRENT DISLOCATION SHOULDER

I. Narrative Description:

A. Open Bankart or Bristow Procedure

II. History/Symptoms:

A. Must meet the following:
- **1.** Multiple recurrent dislocations that inhibit activities of daily living

AND

III. Diagnostic Testing:

A. X-ray - **Allowed**
- **1.** X-Ray to either confirm dislocation or exclude a fracture or other bony abnormalitites

IV. Special Instructions:

A. *A second surgical opinion and psychiatric/psychological evaluation will be obtained if this is a second request for this procedure.*

V. Level of Care Required:

A. *Inpatient*

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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 11 - REPAIR OF BICEPS TENDON
PROXIMAL RUPTURE OF THE BICEPS
SHOULDER

I. Narrative Description:

A. Repair Biceps Tendon

II. History/Symptoms:

A. Must meet the following:
- **1.** Clinical history of more than normal amount of pain unresolved with attempts to use arm

AND

III. Physical Findings:

A. Must meet the following:
- **1.** Palpable bulge in upper aspect of arm

AND

IV. Diagnostic Testing:

A. Not applicable

V. Special Instructions:

A. 90% do not need repair.

B. *Consideration of tenodesis should include the following:*
- ***1.*** *Patient should be a young adult;* ***or***
- ***2.*** *Procedure should be done in conjunction with another open repair;* ***or***
- ***3.*** *There should be evidence of an incomplete tear.*

VI. Level of Care Required:

A. *Outpatient*

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REVIEW CRITERIA
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CRITERIA NUMBER 12 - REPAIR OF BICEPS TENDON
DISTAL RUPTURE OF THE BICEPS
SHOULDER

I. Narrative Description:

A. Repair Biceps Tendon

II. History/Symptoms:

A. Must meet the following:
1. Pain

AND

III. Physical Findings:

A. Must meet the following:
1. Inability of physician to palpate the insertion of the tendon at the patient's antecubital fossa

AND

IV. Diagnostic Testing:

A. Not applicable

V. Special Instructions:

A. *Should be repaired within one week of injury or diagnosis.*

VI. Level of Care Required:

A. *Outpatient*

COMMONWEALTH OF MASSACHUSETTS
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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 13 - SHOULDER ARTHROSCOPY FOR DIAGNOSTIC PURPOSES SHOULDER

I. Narrative Description:

A. Shoulder Arthroscopy for Diagnostic purposes

II. History/Symptoms:

A. Must meet the following:
- **1.** Acute pain; **or**
- **2.** Limitation of function despite conservative treatment

AND

III. Physical Findings:

A. Must meet the following:
- **1.** Diminution of function

AND

IV. Diagnostic Testing:

A. Imaging inconclusive

V. Special Instructions:

A. *Request for inpatient setting will be reviewed by a Physician Reviewer.*

VI. Level of Care Required:

A. *Outpatient*

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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 14 - ANTERIOR CRUCIATE LIGAMENT (ACL) REPAIR KNEE

I. Narrative Description:

A. Anterior Cruciate Ligament (ACL) Repair

II. History/Symptoms:

A. Must meet **B** and **1** or **2**:

B. Instability of the knee (buckling or giving way); **and**
- **1.** Significant effusion at the time of injury; **or**
- **2.** Description of injury indicating a rotary twisting or hyperextension occurred

AND

III. Physical Findings:

A. Must meet **B** and **1** or **2** or **3**:

B. Positive Lachmans sign; **and**
- **1.** Positive pivot shift; **or**
- **2.** Positive anterior drawer; **or**
- **3.** Positive KT 1000, > 3-5mm = +1
  > 5-7mm = +2
  > 7 mm = +3

AND

IV. Diagnostic Testing:

A. Positive findings of one of the following:
- **1.** Arthrogram; **or**
- **2.** MRI; **or**
- **3.** Arthroscopy

V. Special Instructions:

A. *None*

VI. Level of Care Required:

A. *Inpatient*

COMMONWEALTH OF MASSACHUSETTS
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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 15 - PATELLA TENDON RE-ALIGNMENT
MAQUET PROCEDURE
KNEE

I. Narrative Description:

A. Patella Tendon Re-Alignment (CPT 27422)

II. History/Symptoms:

A. Must meet the following:
- **1.** Rest-sitting pain

AND

III. Physical Findings:

A. Must meet one of the following:
- **1.** Pain with patellar/femoral movement; **or**
- **2.** Recurrent dislocations

AND

IV. Diagnostic Testing:

A. Must meet the following:
- **1.** Recurrent effusions; **and**
- **2.** Patella apprehension; **and**
- **3.** Synovitis; **and**
- **4.** Lateral tracking; **and**
- **5.** Increased Q angle > 15 degrees

V. Special Instructions:

A. *None*

VI. Level of Care Required:

A. *Inpatient*

COMMONWEALTH OF MASSACHUSETTS
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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 16 - KNEE JOINT REPLACEMENT

I. Narrative Description:

A. Knee Joint Replacement

II. History/Symptoms:

A. Must meet all of the following:
- **1.** Limited range of motion; **and**
- **2.** Night pain; **and**
- **3.** No relief of pain with conservative care

AND

III. Physical Findings:

A. Not Addressed in Guideline

AND

IV. Diagnostic Testing:

A. Positive findings (significant loss or erosion of cartilage to the bone) of one of the following:
- **1.** Standing x-rays; **or**
- **2.** Arthroscopy

V. Special Instructions:

A. *If 2 or 3 knee compartments are affected a total joint replacement is indicated. If only one knee compartment is affected, a unicompartmental or partial replacement is indicated.*

VI. Level of Care Required:

A. *Inpatient*

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REVIEW CRITERIA
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CRITERIA NUMBER 17 - LATERAL LIGAMENT ANKLE RECONSTRUCTION FOR CHRONIC INSTABILITY OF ANKLE

I. Narrative Description:

A. Lateral Ligament Ankle Reconstruction

II. History/Symptoms:

A. Must meet the following:
- **1.** Instability of the ankle
  - **a.** Buckling; **or**
  - **b.** Giving away

OR

- **2.** Supportive Findings:
  - **a.** Complaint of swelling; **or**
  - **b.** Complaint of pain

AND

III. Physical Findings:

A. Must meet the following:
- **1.** Positive anterior drawer

AND

IV. Diagnostic Testing:

A. Abnormal test results of the following:
- **1.** Must meet **a** and **b**, or **c**
  - **a.** Positive stress x-rays identifying motion at the ankle or subtalar joint, at least 15^{o} lateral opening at the ankle joint; **or**
  - **b.** Demonstrable subtalar movement; **and**
  - **c.** Negative to minimal arthritic joint changes on x-ray.

AND

V. Failure to improve with conservative treatment with:

A. Immobilization with support cast or brace; **or**

B. Rehabilitation program

C. For either of the above, the time frame will vary dependent on the severity of the injury/trauma.

VI. Special Instructions:

A. *None*

VII. Level of Care Required:

A. *Outpatient or Inpatient depending on patient*

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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 18 - LATERAL LIGAMENT ANKLE RECONSTRUCTION FOR ACUTE ANKLE SPRAIN/STRAIN INVERSION INJURY

I. Narrative Description:

A. Lateral Ligament Ankle Reconstruction

II. History/Symptoms:

A. Must meet one of the following:
1. Description of inversion; **or**
2. Hyperextension injury with ecchymosis or swelling

AND

III. Physical Findings:

A. Must meet the following:
1. Positive anterior drawer; **and**
2. Grade 3 injury (lateral injury); **or**
3. Osteochondral fragment; **or**
4. Medial incompetence

AND

IV. Diagnostic Testing:

A. Abnormal test results of the following:
1. Negative to minimal arthritic joint changes on x-ray; **and**
2. Positive stress x-rays identifying motion at the ankle or subtalar joint, at least 15^{o} lateral opening at the ankle joint; **or**
3. Demonstrable subtalar movement

AND

V. Failure to improve with conservative treatment with:

A. Immobilization with support cast or brace; **or**

B. Rehabilitation program

C. For either of the above, the time frame will vary dependent on the severity of the injury/trauma.

VI. Special Instructions:

A. *None*

VII. Level of Care Required:

A. *Outpatient or Inpatient depending on patient*

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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 19 - FUSION ANKLE-TARSAL-METATARSAL TO TREAT NON-UNION OR MALUNION OF A FRACTURE OR TRAUMATIC ARTHRITIS SECONDARY TO ON THE JOB INJURY TO THE AFFECTED JOINT

I. Narrative Description:

A. Fusiont

B. Ankle-Tarsal

C. Metatarsal

II. History/Symptoms:

A. Must meet the following:
- **1.** Pain including that which is aggravated by activity and weight-bearing; **and**
- **2.** Pain relieved by Xylocaine injection

AND

III. Physical Findings:

A. Must meet the following:
- **1.** Malalignment; **and**
- **2.** Decreased range of motion

AND

IV. Diagnostic Testing:

A. X-ray confirming presence of:
- **1.** Loss of articular cartilage (arthritis); **or**
- **2.** Bone deformity (hypertrophic spurring or sclerosis); **or**
- **3.** Non or mal-union of a fracture

AND

V. Failure to improve with the following:

A. Casting or bracing; **or**

B. Shoe modification or orthotics; **or**

C. Anti-inflammatory medications

VI. Special Instructions:

A. *Supporting imaging could include: Bone Scan (for arthritis only) to confirm localization, MRI, or Tomography.*

VII. Level of Care Required:

A. *Outpatient*

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REVIEW CRITERIA
REVISED EFFECTIVE DECEMBER 1, 1999

CRITERIA NUMBER 20
DIAGNOSIS AND TREATMENT OF NECK AND BACK (SPINAL) INJURIES

CONSERVATIVE OUTPATIENT TREATMENT
(UP TO 6 WEEKS FROM DATE OF INJURY)

I. Symptoms:

A. Pain in the back or neck area that may include the leg or the arm.

II. Exclusions: (if an injured worker experiences back or neck pain in the presence of the following conditions, this criteria would not apply):

A. concurrent unexplained fever over 48 hours; **or**

B. neoplasm; **or**

C. severe trauma - such as fracture or ligamentous injury; **or**

D. documented specific diagnoses (rheumatoid arthritis, herniated disc, spinal stenosis, spondylolisthesis, congenital fusion, diastematomyelia, hemivertebra, spinal osteomyelitis, prior spinal surgery at the same level); **or**

E. a history of documented severe radicular pain and paresthesias related to neck movement and physical findings displaying motor weakness and reflex changes; **or**

F. impaired bowel and bladder function; **or**

G. increasing pain and/or symptoms, despite treatment; **or**

H. Age > 50 years.

III. Diagnostic Testing Allowed: (Up to 6 weeks from date of injury):

A. X-rays:
- **1.** Back - Maximum 4 views (one study allowed)
- **2.** Neck - Maximum 5 views (one study allowed)

IV. Diagnostic Testing Not Allowed:

A. CT, MRI, Bone Scan

B. Computer Back Testing (CBT)

C. EMG and Nerve Conduction Studies

D. Functional Capacity Evaluation (FCE)

E. Work Capacity Evaluation (WCE)

F. Thermogram

G. Myelogram

H. Evoked Potentials

V. Outpatient Treatment Modalities Allowed (Within scope of license):

A. Bedrest - maximum 2 days

B. Prescribed non-narcotic analgesics: Muscle relaxants, nonsteroidal anti-inflammatory drugs

C. Narcotics - maximum 5 day course

D. Trigger point injection - maximum 2 injections within 4 weeks

E. Lumbar support

F. Cervical collar

G. Traction (Neck)

H. Manual therapy/spinal adjustment/manipulation

I. Therapeutic exercise (under the direct supervision of a licensed healthcare provider)

J. Patient education including activities of daily living, joint protection techniques, and back pain recovery and prevention - encouraged

K. Modified work activity through the recovery process - encouraged

L. Physical agents and modalities e.g. (heat/cold, electrical stimulation, iontophoresis/phonophoresis, ultrasound, fluori-methane) maximum of 2 allowed per treatment session

VI. Outpatient Office Visits Allowed:

A. Physician - maximum four (4) visits in first 6 weeks

B. Physical Therapy - maximum eighteen (18) visits in first 6 weeks

C. Occupational Therapy - maximum six (6) visits in first 6 weeks

D. Chiropractic Medicine - maximum eighteen (18) visits in first 6 weeks

VII. Outpatient Treatment Modalities Not Allowed:

A. Facet injection

B. Epidural block

C. Spinal Traction (Back)

D. Physical agents and modalities e.g. (heat/cold, electrical stimulation, iontophoresis/phonophoresis, ultrasound, fluori-methane) if only treatment procedure

VIII. Special Instructions:

A. *Similar discipline services shall not be duplicated for injured workers treated by more than one discipline (e.g. Physical Therapy, Occupational Therapy, Allopathic Medicine and Chiropractic Medicine).*

IX. Level of Care Required:

A. *Outpatient*

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REVIEW CRITERIA
REVISED EFFECTIVE DECEMBER 1, 1999

CRITERIA NUMBER 21 - DIAGNOSIS AND TREATMENT OF NECK AND BACK (SPINAL) INJURIES

CONSERVATIVE OUTPATIENT TREATMENT (FROM 7 TO 12 WEEKS FROM DATE OF INJURY)

I. Inclusions:

A. The following persistent conditions would be included in these criteria:
1. return to part or full time work with limiting symptoms; **or**
2. symptoms unimproved over 3 weeks with treatment; **or**
3. not back to work with symptoms (supported by objective findings); **or**
4. symptoms over 2 weeks without treatment.

II. Diagnostic Testing Allowed: (From 7 to 12 weeks from date of injury, unless the test has been previously completed):

A. X-rays:
1. back - Maximum 4 views (one study **allowed**)
2. neck - Maximum 5 views (one study **allowed**)

B. FCE or WCE (one study allowed): must be supported by objective findings and measurements

III. Diagnostic Tests Not Allowed:

A. MRI, CT scan, Bone Scan*

B. Computer Back Testing

C. EMG and Nerve Conduction Studies

D. Thermogram

E. Myelogram

F. Evoked Potentials

***Exception:** An MRI, CT Scan or Bone Scan (**one Study**) **is allowed** under the following circumstances:
1. an emergency, serious, underlying medical condition; **or**
2. physiological evidence of neurological dysfunction; **or**
3. failure to progress or respond.

1. an emergency, serious, underlying medical condition; **or**
2. physiological evidence of neurological dysfunction; **or**
3. failure to progress or respond.

IV. Outpatient Treatment Modalities Allowed:

A. prescribed non-narcotic analgesics, muscle relaxants, non-steroidal anti-inflammatory agents

B. traction (neck)

C. trigger point injection - maximum of one injection between weeks 7 and 12 only

D. manual therapy/spinal adjustment/manipulation

E. physical agents (heat/cold, electrical stimulation, iontophoresis/phonophoresis, ultrasound, flouri-methane)- maximum of 1 allowed per session

F. patient education regarding activities of daily living and joint protection techniques, monitored exercise – encouraged

G. activity - formal employer contact for transitional/modified work availability- encouraged

V. Outpatient Treatment *Not* Allowed:

A. Scheduled narcotic medication

B. spinal traction (back)

C. TENS

D. physical agents (heat/cold, electrical stimulation, iontophoresis/phonophoresis, ultrasound, flouri-methane)- ***not allowed*** as the only treatment

VI. Outpatient Office Visits Allowed:

A. Medical - maximum two (2) visits between weeks 7 and 12

B. Chiropractic Medicine - maximum ten (10) visits between weeks 7 and 12

C. Occupational Therapy - maximum ten (10) visits between weeks 7 and 12

D. Physical Therapy - maximum ten (10) visits between weeks 7 and 12

VII. Special Instructions:

A. Similar discipline services shall not be duplicated for injured workers treated by more than one discipline (e.g., Physical Therapy, Occupational Therapy, Allopathic Medicine, and Chiropractic Medicine).

B. *For review criteria for treatment beyond 12 weeks from date of injury, see review criteria # 26 or #27.*

VIII. Level of Care Required:

A. *Outpatient*

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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 22 - SURGERY FOR CERVICAL RADICULOPATHY FOR ENTRAPMENT OF A SINGLE NERVE ROOT

I. Narrative Description:

A. Decompression for entrapment of a single nerve root, including, but not limited to:
- **1.** Cervical
  - **a.** Laminectomy
  - **b.** Diskectomy
  - **c.** Laminotomy
- **2.** Foraminotomy with or without fusion, excluding fracture

II. History/Symptoms:

A. Sensory symptoms in a dermatomal distribution such as:
- **1.** Radiating pain; **or**
- **2.** Paresthesia; **or**
- **3.** Tingling; **or**
- **4.** Burning sensation; **or**
- **5.** Numbness

AND

III. Physical Findings:

A. Must meet one or more of the following:

B. Dermatomal sensory deficit; **or**

C. Motor deficit; **or**

D. Reflex changes; **or**

E. Positive EMG

AND

IV. Diagnostic Testing:

A. Abnormal test results that correlate with the level of nerve root involvement consistent with history and physical findings such as:
- **1.** CT scan; **or**
- **2.** MRI; **or**
- **3.** Myelogram

AND

V. Failure to improve with a minimum of 6 to 8 weeks of conservative treatment:

A. For Example:
- **1.** Physical modalities; **and/or**
- **2.** Non-steroidal anti-inflammatory agents; **and/or**
- **3.** Cervical traction

VI. Special Instructions:

A. *Refer cases that fall into the following range:*
- ***1.*** *repeat surgery at the same level*
- ***2.*** *request for surgery at the C3-4 level*
- ***3.*** *request for surgery with signs and symptoms indicating myelopathy*
- ***4.*** *any case not meeting criteria*

B. *When requesting authorization for decompression of multiple level nerve roots, each level is subject to the criteria.*

VII. Level of Care Required:

A. *Inpatient*

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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 23 - DIAGNOSIS AND OUTPATIENT TREATMENT OF A SINGLE LUMBAR SPINAL NERVE ROOT ENTRAPMENT

I. Narrative Description:

A. Herniated Lumbar Disk

II. History/Symptoms:

A. Must meet one of the following:
- **1.** Radicular pain within nerve root distribution; **or**
- **2.** Bowel and bladder dysfunction; **or**
- **3.** Weakness or sensory disturbance in limb

AND

III. Physical Findings:

A. One required to be positive in order to proceed with diagnostic test.

B. Atrophy of calf or thigh; **or**

C. Segmental motor loss; **or**

D. Femoral stretch test positive; **or**

E. Knee or ankle reflex (including posterior tibial) decrease; **or**

F. Sensory loss in distribution of nerve root pattern; **or**

G. Positive straight leg raising producing leg pain confirmed in sitting and supine position

IV. Allowed Diagnostic Testing:

A. Maximum of three tests performed if results negative.

B. Low back x-rays if not done since injury (should precede B through F); **or**

C. CT scan; **or**

D. MRI; **or**

E. Myelogram; **or**

F. Bone scan; **or**

G. EMG

H. NOTE: F and G above should not be used as the only diagnostic test.

V. <u>Treatment Measures (Maximum duration of treatment in six months from date of injury</u>):

A. Physician office treatment sessions (maximum of 12); **and/or**

B. Physical therapy (maximum of 42 visits); **and/or**

C. Occupational therapy (maximum of 6 visits); **and/or**

D. Chiropractic treatment (maximum of 42 visits); **and/or**

E. Physical agents (heat/cold, electrical stimulation, traction, biofeedback, iontophoresis/phonophoresis, ultrasound, fluori-methane) maximum of 2 allowed per treatment session - **not allowed if only treatment**; **and/or**

F. Lumber Support – **Allowed**; **and/or**

G. Epidural steroid injection (maximum of 3); **and/or**

H. Facet injection (maximum 3); **and/or**

I. Medications
- **a.** Narcotic medication (not over 6 weeks duration in treatment).
- **b.** Non-narcotic analgesics, muscle relaxants, nonsteroidal anti-inflammatory drugs - no limit

J. Rehabilitation referral (patient education, aerobic and job specific exercise, functional capacity test) - **Allowed**

K. Activities of daily living, joint protection techniques, back pain recovery and prevention

L. Manual therapy/spinal adjustment/manipulation - **Allowed**

VI. Special Instructions:

A. *For patient treated by more than one discipline, (physical therapy, occupational therapy, chiropractic etc.) services should not be duplicated.*

B. *The following diagnostic tests are not allowed: Myeloscopy, Discography, and Somatosensory Evoked Potentials Thermography.*

VII. Level of Care Required:

A. *Outpatient*

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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 24 - OPERATIVE TREATMENT OF A SINGLE LUMBAR SPINAL NERVE ROOT ENTRAPMENT

I. Narrative Description:

A. Lumbar:
- **1.** Laminectomy
- **2.** Laminotomy
- **3.** Foraminotomy
- **4.** Micro-Diskectomy
- **5.** Diskectomy
- **6.** Lumbar Fusion
- **7.** Foraminal Decompression

II. History/Symptoms:

A. Must meet one of the following:
- **1.** Radicular pain within nerve root distribution; **or**
- **2.** Bowel and bladder dysfunction; **or**
- **3.** Weakness or sensory disturbance in limb; **or**
- **4.** Inability to control pain on an outpatient basis; **or**
- **5.** Inability to maintain activity required for outpatient status because of non-supportive home situation

AND

III. Physical Findings:

A. Must meet **B** and one from **C** through **G**:

B. Radiating (radicular) leg pain greater than back pain; **and**

C. Evidence of neurologic deficit in the distribution of a single lumbar spinal nerve such as:
- **1.** Motor deficit (e.g., foot drop or quadriceps weakness); **or**
- **2.** Sensory deficit; **or**
- **3.** Reflex changes; **or**
- **4.** Positive EMG

D. Atrophy of calf or thigh

E. Positive femoral stretch

F. Positive straight or reversed straight leg raising producing leg pain confirmed in 2 anatomic positions (sitting and supine)

G. Documented (MRI, CT scan or myelogram) evidence of nerve root compression

AND

IV. Diagnostic Testing - Allowed:

A. Maximun of 3, if results negative:
- **1.** Low back x-rays, if not done since injury
- **2.** Bone scan (not as only diagnostic test)
- **3.** EMG (not as sole diagnostic test or under 21 days from onset of symptoms)
- **4.** Laboratory testing of metabolic or oncologic diagnosis suspected

B. One of the following - test must demonstrate nerve root compression:
- **1.** MRI; **or**
- **2.** CT scan; **or**
- **3.** Myelogram

OR

V. Diagnostic Testing - Not Allowed:

A. Myeloscopy

B. Discography

C. Somatosensory evoked potentials

D. Thermography

E. Evoked potentials

VI. Post Hospital Treatment Allowed:

A. Office visits - 5 in first 4 months

B. Physical therapy treatment sessions maximum 24 visits

C. Occupational therapy - maximum 6 visits

D. Chiropractic sessions - maximum 24 visits

E. Physical agents (heat/cold, electrical stimulation, biofeedback, iontophoresis/phonophoresis, ultrasound, flouri-methane) maximum of 1 allowed per treatment session - not allowed if only treatment - generally de-emphasized

VII. Special Instructions:

A. *Length of stay postoperatively is 0-5 days (7 days for spinal fusion).*

B. *For patients treated by more than one discipline (physical therapy, occupational therapy,allopathic medicine, and chiropractic) similar services should not be duplicated.*

VIII. Level of Care Required:

A. *Inpatient*

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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 25 - CAUDA EQUINA SYNDROME

I. Narrative Description:

A. Lumbar:
- **1.** Laminectomy
- **2.** Diskectomy
- **3.** Micro-Diskectomy

II. History/Symptoms:

A. Sudden onset or rapid progression of sensory symptoms

AND

III. Physical Findings:

A. Must meet one of the following:
- **1.** Neurologic exam showing:
  - **a.** Deficit that is bilateral; **or**
  - **b.** Involves multiple neurologic levels

AND

IV. Diagnostic Testing:

A. Must meet one of the following:
- **1.** CT scan; **or**
- **2.** MRI; **or**
- **3.** Myelogram

B. Positive finding demonstrating a large lesion producing central-stenosis with tight obstruction.

V. Special Instructions:

A. *Early surgical intervention.*

VI. Level of Care Required:

A. *Inpatient*

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REVIEW CRITERIA
EFFECTIVE OCTOBER 1, 1998

CRITERIA NUMBER 26 - CHRONIC NEUROMUSCULO-SKELETAL INJURY

I. Narrative Description:

A. Chronic Neuromusculo-Skeletal Injury

II. History/Symptoms:

A. Must meet the following:

B. Injured worker is employed; **and**
- **1.** Has functional impairment related to injury; **or**
- **2.** Has residual clinical findings that may result in limitation of activities of daily living **and** work related activities; **and**

C. Completed applicable treatment guideline for primary diagnosis; **and**

D. Maximum Medical Improvement (MMI) has not been reached (determined by treating practitioner); **and**

E. Recurrent or residual neuromusculo-skeletal symptoms exist

AND

III. Diagnostic Testing Allowed:

A. None

AND

IV. Treatment Measures Allowed (within scope of license):

A. The following are allowed in an eight (8) month period from the end point of the primary diagnosis Neuromusculo-Skeletal Injury guideline:
- **1.** Medical visits (max. 4 visits)
- **2.** Physical therapy (max. 16 visits)
- **3.** Occupational therapy (max. 16 visits)
- **4.** Chiropractic (max. 16 visits)

B. Physical agents and modalities (max. 2 allowed per treatment session)
- **1.** Heat/cold
- **2.** Electrical stimulation
- **3.** Iontophoresis/phonophoresis
- **4.** Ultrasound
- **5.** Flouri-methane
- **6.** Cold laser

AND

V. Discharge Planning Required:

A. Office of Education and Vocational Rehabilitation referral form completed and sent to the DIA (signed by treating practicioner)

VI. Special Instructions:

A. *Physical agents and modalities are not allowed as the only treatment.*

B. *Home equipment is not allowed (eg. home whirlpools, hot tubs, special beds or mattresses, waterbed, recliner or lounge chairs, electro-sleep devices, electrical nerve (TENS) or muscle stimulators).*

C. *Duplication of any services for patients being treated by more than one discipline is not allowed.*

D. *Re-entry into this guideline for the same diagnosis is not allowed.*

E. *At conclusion of this guideline, the patient should be considered at maximum medical improvement and rated according to the most current AMA Impairment Guide.*

F. *Non-compliance with the treatment program, as determined by the treating practicioner, will result in immediate termination from this guideline.*

G. *Patients with Chronic Pain Syndrome are excluded from this guideline.*

H. *Inpatient treatment is not allowed.*

VII. Level of Care:

A. *Outpatient*

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REVIEW CRITERIA
EFFECTIVE OCTOBER 1, 1998

CRITERIA NUMBER 27 - CHRONIC PAIN SYNDROME

I. Narrative Description:

A. Chronic Pain Syndrome

II. History/Symptoms:

A. Must meet the following:

1. Chronic Pain Syndrome diagnosed by treating practitioner; **and**
2. Maximum medical improvement of primary diagnosis; **or**
3. Recommendation by treating practicioner for chronic pain program; **and**
4. Chronic pain that would not be expected from patient's history and physical exam; **and**
5. Chronic pain with significant impairment, despite apparent healing of underlying pathology; **and**
6. Recovery exceeded expected duration of treatment for primary diagnosis; **and**
7. Intensive utilization of medical services and drugs; **or**
8. Persistent complaints of pain; **or**
9. Symptoms of anxiety**; or**
10. Depression; **or**
11. Anger; **or**
12. Other manifestations of chronic pain

AND

III. Diagnostic Testing Allowed:

A. None

AND

IV. Treatment Measures Allowed (within scope of license):

A. Evaluation by multidisciplinary treatment team (required) (only one allowed)

B. Treatment Plan developed by multidisciplinary team (required)

C. Patient Contract must be developed within 7 calendar days of the initial evaluation (required)

D. Physical Capacity Evaluation (one)

E. Withdrawal program from medication (required)

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F. Work conditioning or work-hardening (max. 20 visits, up to 4 hours/visit)

G. Psychotherapy (max. 15 visits)

H. Physical Therapy (max. 20 visits)

I. Occupational Therapy (max. 20 visits)

J. Chiropractic (max. 20 visits)

K. Physical modalities (max. 2 allowed per treatment session - not allowed as only treatment procedure)

1. Heat/cold
2. Electrical Stimulation
3. Iontophoresis
4. Phonophoresis
5. Ultrasound
6. Flouri-methane
7. Cold laser

AND

V. **Discharge Planning Required:**

A. Summary report by treatment team; **and**

B. Office of Education and Vocational Rehabilitation referral form completed and sent to DIA (signed by Program Coordinator)

VI. Special Instructions:

A. *Treatment team shall include a licensed mental health professional (psychiatrist or psychologist) and no more than three (3) of the following: physician, physical therapist, occupational therapist, or chiropractor. At least one member must have training or experience with chronic pain patients. No member of the treatment team shall be a practitioner who has previously examined, ordered medical care for, rendered medical care to, or reviewed the medical record of, the injured employee.*

B. *Program Coordinator must be assigned from the pain program/treatment team to coordinate clinical care.*

C. *Non-compliance with the Patient Contract will result in termination from the treatment program, to be determined by Program Coordinator.*

D. *Return to work should be strongly encouraged.*

E. *Home equipment is not allowed (eg. home whirlpool, hot tubs, special beds or mattresses, waterbeds, recliner or lounge chairs, electro-sleep devices, electrical nerve (TENS) or muscle simulators).*

F. *Physical modalities are not allowed as the only treatment procedure.*

G. *For patients treated by more than one discipline (physical therapy, occupational therapy, chiropractic, etc.), services should not be duplicated.*

H. *Patients whose primary diagnosis changes, causing eligibility to another guideline, are excluded from this guideline.*

VII. Level of Care (only one setting allowed):

A. *Inpatient Chronic Pain Program, three (3) weeks;* ***or***

B. *Outpatient Chronic Pain Program, eight (8) weeks.*

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GUIDELINE NUMBER 28 - DIAGNOSIS AND INITIAL TREATMENT OF OCCUPATIONAL ASTHMA

I. Narrative Description:

A. Occupational Asthma

II. History/Symptoms:

A. Must meet the following:
- **1.** Asthma diagnosed by medical doctor; **and**
- **2.** Historical association between onset of asthma and work

OR

- **3.** A diagnosis of Occupational Asthma; and
- **4.** A history of asthma prior to the occupational exposure in question

AND

- **5.** Documentation of workplace exposure to a category of agents or processes associated with asthma; **or**
  - **a.** Work-related change in FEV1 or in peak expiratory flow (PEF); or
  - **b.** Onset of respiratory signs and/or symptoms within hours after an acute, high level, occupational inhalation exposure to an irritant (RADS)

AND

III. Diagnostic Testing Allowed:

A. Spirometry Studies, consisting of a minimum of 3 and a maximum of 8 *maneuvers* (max. 11 *studies* allowed); **and**
- **1.** The initial study is performed pre- and post-inhaled bronchodilator (required); **and**
- **2.** *No more than* 2 follow-up studies are allowed to establish a diagnosis of asthma; **and**
- **3.** *No more than* 8 pre- and post-shift studies at the beginning and end of each work week for 2 weeks max. allowed; **and**
- **4.** Peak Expiratory Flow (PEF) tests taken *by the patient* (required); **and**
  - **a.** The best of at least 3 maneuver *readings* per test recorded by the patient (required); **and**
  - **b.** Tests taken at the same time each day, 4 to 5 times per day; **and**
  - **c.** Taken 7 days per week (max. 4 weeks); **and**
- **5.** If PEF diary and spirometric monitoring are equivocal, then
  - **a.** 1 repeat study (max.) allowed at beginning of absence from work; **and**
  - **b.** 1 repeat study (max.) allowed at end of absence from work; **and**
  - **c.** PEF diary monitoring repeated

B. A Non-Specific Inhalation Challenge Test (one allowed)

IF

1. No significant improvement in FEV1 in response to inhaled brochodilator; **and**
2. Existence of airways hyper-reactivity remains in question; **and**
3. Test is performed in a hospital-based outpatient setting (required); **and**
4. Performed consistent with Treatment Guideline Number 28 appended algorithm (required); **and**
5. Under the supervision of a medical doctor experienced in this procedure (required)

C. A Specific Inhalation Challenge Test (one allowed) and/or Specific Skin Tests (max. 10 allowed) with relevant antigens

IF

1. Performed by a medical doctor experienced in this procedure (required); **and**
2. Performed in a *hospital-based* outpatient setting (required)

D. Chest x-rays (max. 1 postero-anterior and 1 lateral view allowed)

E. Latex and laboratory animal dander RAST tests (max. 1 allowed per antigen)

IV. Treatment Measures Allowed (within scope of license):

A. *Documentation in the medical record of discussion with the patient of risk of severe bronchospasm and/or death in the event of re-exposure, where the workplace exposure was to a sensitizing agent;*

B. *Documentation in the medical record of discussion with the patient of the advisability of climination or significant reduction of exposure through the use of engineering controls and/or respiratory protection provided by the employer;*

AND

C. *Stepwise approach to pharmacological treatment of asthma according to the Guidelines;*

AND

D. *Documentation in the medical record that the physician has educated the patient with regard to important asthma signs and symptoms, issues around treatment, and monitoring of status.*

V. Discharge Plan Required:

A. *Documentation in the medical record that diagnosis is established and that the patient's asthma is stable with regard to symptoms and lung function prior to discharge from this Guideline*